General

Guideline Title

Olaparib for maintenance treatment of relapsed, platinum-sensitive, BRCA mutation-positive ovarian, fallopian tube and peritoneal cancer after response to second-line or subsequent platinum-based chemotherapy.

Bibliographic Source(s)

National Institute for Health and Care Excellence (NICE). Olaparib for maintenance treatment of relapsed, platinum-sensitive, BRCA mutation-positive ovarian, fallopian tube and peritoneal cancer after response to second-line or subsequent platinum based chemotherapy. London (UK): National Institute for Health and Care Excellence (NICE); 2016 Jan 27. 44 p. (Technology appraisal guidance; no. 381).

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Recommendations

Major Recommendations

Olaparib is recommended within its marketing authorisation as an option for treating adults with relapsed, platinum sensitive ovarian, fallopian tube or peritoneal cancer who have breast cancer susceptibility gene (BRCA1 or BRCA2) mutations and whose disease has responded to platinum based chemotherapy only if:

- They have had 3 or more courses of platinum based chemotherapy and
- The drug cost of olaparib for people who remain on treatment after 15 months will be met by the company

People whose treatment with olaparib is not recommended in this National Institute for Health and Care Excellence (NICE) guidance, but were started within the National Health Service (NHS) before this guidance was published, should be able to continue treatment until they and their NHS clinician consider it appropriate to stop.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Relapsed, platinum-sensitive, breast cancer susceptibility gene (BRCA) mutation-positive ovarian, fallopian tube and peritoneal cancer

Guideline Category

Assessment of Therapeutic Effectiveness

Treatment

Clinical Specialty

Obstetrics and Gynecology

Oncology

Intended Users

Advanced Practice Nurses

Physician Assistants

Physicians

Guideline Objective(s)

To assess the clinical effectiveness and cost-effectiveness of olaparib for maintenance treatment of relapsed, platinum-sensitive, breast cancer susceptibility gene (BRCA) mutation-positive ovarian, fallopian tube and peritoneal cancer after response to second-line or subsequent platinum-based chemotherapy

Target Population

Adult women with relapsed, platinum-sensitive, breast cancer susceptibility gene (BRCA) mutation-positive ovarian, fallopian tube and peritoneal cancer after response to second-line or subsequent platinum-based chemotherapy

Interventions and Practices Considered

Olaparib

Major Outcomes Considered

- Clinical effectiveness
  - Overall survival (OS)
  - Progression-free survival (PFS)
  - Time to treatment discontinuation or death (TTD/D)
  - Time to first subsequent therapy or death (TFST/D)
  - Time to second subsequent therapy or death (TSST/D)
  - Adverse events (AEs) of treatment
  - Health-related quality of life
- Cost-effectiveness

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Searches of Unpublished Data

Description of Methods Used to Collect/Select the Evidence

Note from the National Guideline Clearinghouse (NGC): The National Institute for Health and Care Excellence (NICE) commissioned an independent academic centre to perform an assessment of the manufacturer's submission on the technology considered in this appraisal and prepare an Evidence Review Group (ERG) report. The ERG report for this technology appraisal was prepared by School of Health and Related Research (ScHARR), University of Sheffield (see the "Availability of Companion Documents" field).

Clinical Effectiveness

Critique of the Methods of Review(s)

The company's submission (CS) presents an unpublished systematic review that originally had a wider scope than the decision problem. The CS states that "In order to focus only on relevant information, studies within the scope of the original systematic review, but outside the scope of this NICE submission were excluded (with accounted reasons)." In doing so, a number of irregularities and omissions are present in the reporting and potentially the conduct of the systematic review.

Searches

Description of Company's Searches

The company's searches for clinical effectiveness studies were clearly reported in the submission. The company reported that the searches comprised a comprehensive search of major biomedical databases, searched from 1st January 1998 to 13th June 2014, but also stated that the review covered the last 15 years. The ERG notes that this minor discrepancy may be due to subsequent search updates.

The company's search strategy including searching of the following databases:

- Excerpta Medica Database (EMBASE®)
- Medical Literature Analysis and Retrieval System Online (MEDLINE®) including MEDLINE In-Process
- Cochrane Central Register of Controlled Trials (CENTRAL).

Abstracts from relevant conference proceedings were also hand-searched for the past three years, including:

- American Society of Clinical Oncology (ASCO)
- European Society for Medical Oncology (ESMO)
- Society of Gynaecological Oncology (SGO)

In addition, the following trial registries were screened for ongoing trials:

- Clinicaltrials.gov
- International Clinical Trials Registry Platform Search Portal (ICTRP)
- Australian and New Zealand Clinical Trials Registry (ANZCTR)
- EU Clinical Trials Register
- PharmNet.Bund (Klinische Prüfungen)

Supplemental searching included bibliographical searching of relevant systematic reviews and meta-analyses.

Critique of the Company's Search Strategy for Clinical Effectiveness Studies

Published and unpublished but completed studies were searched in the relevant databases, conference proceedings Web sites and several clinical trials registries. The applied restrictions were justified in the CS. Search strategies for both the original and updated search were transparent and fully reported in the CS. The original search and updated search strategies contained a comprehensive list of known drug therapies for the treatment of ovarian cancer, although these were not comparators to olaparib. The keywords used in the additional searches of conference proceedings were not reported and hence searches were not replicated by the ERG.

On 6th February 2015, the ERG re-ran the company's clinical effectiveness review search in PubMed for studies published since April 2014. A total of 30 records were retrieved and considered; no further relevant studies were identified. However, it should be noted that the ERG did not attempt to repeat all of the company's searches due to time constraints.

Inclusion Criteria and Study Selection

Inclusion Criteria

Eligibility Criteria Used in Search Strategy

Criteria	Inclusion	Exclusion
Study Design	RCTs (irrespective of blinding status)	Studies other than RCTs, i.e., non-randomised trials, prospective cohort studies, retrospective cohort studies, single-arm studies, case studies, case reports, case-control, and cross-sectional studies
Population	Adult women of any race	Studies focusing on children or adolescents only (unless a mixed population with relevant subgroup data is reported)
Disease	Patients with OC defined as epithelial ovarian, fallopian tube, or primary peritoneal cancer	Any cancer other than OC (unless a mixed population with relevant subgroup data is reported)
Platinum Status	Patients with platinum-sensitive OC (platinum sensitive is defined as relapse ≥6 months after the cessation of prior chemotherapy) and in complete or partial remission after two or more platinum-based regimens	Studies of platinum-resistant or refractory patients (defined as relapse during prior chemotherapy or within 6 months) will be excluded.
Disease Stage	Stages II–IV	Studies in disease stage I alone will be excluded.
Histological Subtype	Any histological type of OC	No exclusion based on histological subtype during the screening phase
Mutation Status	• Any *BRCA1* or *BRCA2* mutation status (present or absent) • Any information regarding mutation status (hereditary or acquired) will be captured if reported	No exclusion will be based on expression of allele status.
Intervention	Olaparib	• Studies investigating the role of other unlicensed treatments, radiotherapy, chemoradiotherapy, hormonal therapy, or surgery • Adjuvant or neoadjuvant therapy
Comparators	Best supportive care/'watch and wait'	Studies comparing interventions not mentioned in the above list
Line of Therapy	Second-line or beyond	Studies investigating first-line maintenance or maintenance immediately following surgery
Language	Only studies with the full text published in English will be included	Studies with an English abstract where the full text is not in English and that meet the inclusion criteria will be flagged
Publication Time Frame	Last 15 years (1998–2013)	Publications before 1998

See Table 2 of the ERG report for information on rationale for inclusion and exclusion.

Abbreviations: BRCA, breast cancer susceptibility gene; OC, ovarian cancer; RCT, randomised controlled trial.

Study Selection

Study selection was conducted by two reviewers independently; disagreements were reconciled by a third reviewer. The ERG considers this to be a high quality methodology. However, the documentation of study selection in terms of study flow was very poor in the CS. Consequently, the ERG requested clarification on the company's process of study selection. Issues and omissions that prevented the ERG from assessing and validating whether study selection had been appropriate were:

- The citations and reasons for the exclusion of full-text articles were not provided in the CS. The ERG sought clarification on this and was provided with a full list of excluded studies. The ERG consulted this list and was satisfied that selection was appropriate to the decision problem.
- Of the 4 studies addressing a maintenance therapy, it was reported that only one study addressed a maintenance treatment relevant to the decision problem set out in the final NICE scope. However, it was not apparent in what way the others did not meet the decision problem. This was later clarified by the company and was judged by the ERG to be acceptable as the other studies were not testing olaparib.
- The PRISMA flowchart (see Figure 6.1 in the CS) was not constructed appropriately in that it did not provide reasons for the exclusion of 163 publications which simply disappear from the diagram. The company provided a revised flow chart in their clarification response (see Appendix 1 of the ERG report).

Overall, the ERG considers the inclusion criteria and study selection process to have been poorly reported to the extent that the relevance of the review to the decision problem could not be adequately determined. Responses to the ERG's request for clarification indicate that the results are probably relevant to the decision problem.

Additional work conducted by the ERG suggests that Study 19 was the only RCT study that is directly relevant to the decision problem.

Cost-effectiveness

ERG Comment on the Company's Systematic Review of Cost-effectiveness Evidence

Description of Company's Systematic Review of Cost-effectiveness Evidence

The company undertook a systematic review of published economic studies and economic evaluations in ovarian cancer in order to (1) identify economic models developed to assess the cost effectiveness of treatments for ovarian cancer, (2) identify costing data that could be used to populate the economic model, and (3) identify data on the economic burden of ovarian cancer.

The company searched the following electronic literature databases using the EMBASE.com and PubMed search interfaces:

- MEDLINE
- MEDLINE In-Process
- EMBASE
- The Cochrane Library (including the National Health Service Economic Evaluation Database [NHS EED])
- EconLit

In addition, the company searched the Web sites of a number of health technology assessment (HTA) agencies in order to retrieve additional studies which may have been missed by the electronic searches (see Section 5.1.1 of the ERG report for the list of Web sites).

A detailed set of inclusion/exclusion criteria are presented in the CS. Studies were included in the review if they related to patients with ovarian cancer and if they were studies which described economic models or the economic burden associated with ovarian cancer. Included studies were restricted to those in which the title and abstract was available in English, which related to humans, and which were published in the last 10 years. Study selection was undertaken according to the inclusion/exclusion criteria, firstly by title and/or abstract and secondly based on the full text of the publication. According to the CS study selection was undertaken by a single reviewer, with auditing of inclusion/exclusion decisions by a second reviewer. Disagreements were resolved through discussion between the two reviewers.

Nine cost-effectiveness analyses of pharmacological interventions for advanced ovarian cancer met the inclusion criteria for the company's review. According to the CS three of these studies were undertaken in the UK, although the ERG notes that the manufacturer's submission for NICE TA284 (bevacizumab in combination with paclitaxel and carboplatin for first-line treatment of advanced ovarian cancer) is not included in the table of included studies but is mentioned in the text of the CS. Only five studies included in the company's review (or 6 studies, including NICE TA284) describe cost-utility analyses in which the outcome assessed relates to the incremental cost per quality-adjusted life year (QALY) gained.

Only one of the included studies reports a health economic comparison of olaparib versus routine surveillance in patients with PSR high-grade serous ovarian cancer after a partial or complete response to a platinum-containing regimen.

See Section 5 of the ERG report for additional information on ERG critique of company's search strategies.

Number of Source Documents

Clinical Effectiveness

One study met the inclusion criteria.

Cost-effectiveness

- One study was included in the review.
- The manufacturer submitted an economic model.

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus

Rating Scheme for the Strength of the Evidence

Not applicable

Methods Used to Analyze the Evidence

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Note from the National Guideline Clearinghouse (NGC): The National Institute for Health and Care Excellence (NICE) commissioned an independent academic centre to perform an assessment of the manufacturer's submission on the technology considered in this appraisal and prepare an Evidence Review Group (ERG) report. The ERG report for this technology appraisal was prepared by School of Health and Related Research (ScHARR), University of Sheffield (see the "Availability of Companion Documents" field).

Clinical Effectiveness

Critique of the Methods of Review(s)

Critique of Data Extraction

The process of data extraction was poorly described within the company's submission (CS); it is simply stated that "data extraction from included studies was carried out in parallel by two independent reviewers, and any discrepancies were reconciled by a third reviewer. Studies with multiple publications were extracted in one grid with multiple publications linked to one another." Whilst the ERG considers double independent data extraction to be a high quality methodology, it is not clear which fields were data extracted, how the data extraction form was developed, or whether it was standardised. However, given the data that are presented and that only one study was included in the company's review, it is unlikely that these omissions obscure any methodological bias.

Quality Assessment

The process of quality assessment was not well described in terms of how it was done or by whom. It is not clear if quality assessment was checked, and if so, how disagreements were reconciled.

Study quality was assessed using the questions listed by NICE in the submission template and are presented in the CS. It is unclear if the quality assessment was conducted against the Clinical Study Report (CSR) or against published articles relating to the study. This is particularly important when assessing outcome reporting bias. As would be expected, the quality assessment appears to relate to the whole study population, rather than the subgroup analysis relating to breast cancer susceptibility gene-mutated (BRCAm) patients. Quality assessment of the study, undertaken both by the company and by the ERG, is provided in Section 4.2.1.5 of the ERG report.

Evidence Synthesis

No evidence synthesis plans were presented in the CS, however, since there was only one relevant study, a formal synthesis was not required.

See Section 4 of the ERG report for additional information on clinical effectiveness analysis.

Cost-effectiveness

Description of the Company's Model

Description of the Company's Health Economic Model Structure and Logic

The company's health economic analysis takes the form of a semi-Markov model whereby sojourn time in each health state is dependent on the time since entry into that state. Tunnel states are used to model health state occupancy over time. The structure of the company's model is shown in Figure 8 of the ERG report. The health states included in the model are defined in terms of whether the patient is "progression-free" (receiving maintenance treatment or discontinued) and whether they have progressed to first subsequent therapy or second subsequent chemotherapy. The model includes five health states: (i) progression-free (on maintenance treatment); (ii) progression-free (discontinued maintenance treatment); (iii) first subsequent chemotherapy (on treatment or discontinued); (iv) second subsequent chemotherapy (on treatment or discontinued), and (v) dead. The trajectory of patients through the model is determined largely by parametric survival curves fitted to four time-to-event (TTE) outcomes derived from Study 19.

- Time from randomisation to treatment discontinuation or death (TTE outcome 1)
- Time from randomisation to first subsequent therapy or death (TTE outcome 2)
- Time from first subsequent therapy to second subsequent therapy or death (TTE outcome 3)
- Time from second subsequent therapy to death (TTE outcome 4)

The trajectory of patients through the health states is also influenced by the probability that a patient leaving the progression-free and first subsequent therapy health states dies rather than progresses to the next state.

All patients enter the model in the "progression-free (on treatment)" state. It should be noted from the outset that whilst this state is referred to as "progression-free", occupancy within this health state is determined by the patient having not progressed to subsequent chemotherapy, rather than the patient being free from documented radiological tumour progression based on Response Evaluation Criteria in Solid Tumours (RECIST) criteria. The probability of being progression-free at time *t* is determined by a parametric survival curve fitted to time-to-event data on the time from randomisation to first subsequent therapy or death (TFST/D) in the *BRCAm* subgroup within Study 19. The proportion of patients in the progression-free state at time *t* is then subdivided into those who are currently receiving maintenance treatment and those who have discontinued maintenance treatment; this is modelled using a parametric survival curve fitted to time-to-event data on the time from randomisation to treatment discontinuation or death (TTD/D) outcome in the BRCAm subgroup within Study 19. The difference between these two modelled curves reflects the proportion of patients who have discontinued maintenance therapy but have not yet started first subsequent chemotherapy. Upon leaving the progression-free state, patients may either die or progress to the first subsequent line of chemotherapy.

See Section 5 of the ERG report for additional information on cost-effectiveness analysis.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Considerations

Technology appraisal recommendations are based on a review of clinical and economic evidence.

Technology Appraisal Process

The National Institute for Health and Care Excellence (NICE) invites 'consultee' and 'commentator' organisations to take part in the appraisal process. Consultee organisations include national groups representing patients and carers, the bodies representing health professionals, and the manufacturers of the technology under review. Consultees are invited to submit evidence during the appraisal and to comment on the appraisal documents.

Commentator organisations include manufacturers of the products with which the technology is being compared, the National Health Service

(NHS) Quality Improvement Scotland and research groups working in the area. They can comment on the evidence and other documents but are not asked to submit evidence themselves.

NICE then commissions an independent academic centre to review published evidence on the technology and prepare an 'assessment report'. Consultees and commentators are invited to comment on the report. The assessment report and the comments on it are then drawn together in a document called the evaluation report.

An independent Appraisal Committee then considers the evaluation report. It holds a meeting where it hears direct, spoken evidence from nominated clinical experts, patients and carers. The Committee uses all the evidence to make its first recommendations, in a document called the Appraisal Consultation Document (ACD). NICE sends all the consultees and commentators a copy of this document and posts it on the NICE Web site. Further comments are invited from everyone taking part.

When the Committee meets again it considers any comments submitted on the ACD; then it prepares its final recommendations in a document called the Final Appraisal Determination (FAD). This is submitted to NICE for approval.

Consultees have a chance to appeal against the final recommendations in the FAD. If there are no appeals, the final recommendations become the basis of the guidance that NICE issues.

Who Is on the Appraisal Committee?

NICE technology appraisal recommendations are prepared by an independent committee. This includes health professionals working in the NHS and people who are familiar with the issues affecting patients and carers. Although the Appraisal Committee seeks the views of organisations representing health professionals, patients, carers, manufacturers and government, its advice is independent of any vested interests.

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

Summary of Appraisal Committee's Key Conclusions

Availability and Nature of Evidence

The Committee noted that the company's model was a semi-Markov-state transition design rather than a more standard partitioned survival model. It concluded that the model was a novel design that lacked external validity, and that the use of sequential intermediate outcomes to model overall survival relied on a large number of assumptions that may not all be reasonable.

Uncertainties Around and Plausibility of Assumptions and Inputs in the Economic Model

The Committee accepted that the choice of appropriate parametric functions to extrapolate observed data for a small number of patients is a challenging and not totally objective process; however, the substantial disagreement between the results from Study 19 and the model predictions undermined confidence in the modelling used by the company. The Committee concluded that the company's model overestimated the benefit of olaparib and therefore underestimated the incremental cost-effectiveness ratio (ICER) for olaparib compared with routine surveillance.

The Committee concluded that although the data may be more complete, there was no evidence that the use of time to first and second subsequent treatment was a more accurate method for calculating overall survival than the more conventional use of planned trial outcomes such as progression-free and overall survival.

The Committee questioned whether an average overall survival benefit of 16.3 months was plausible, and noted that the modelling method did not utilise any of the overall survival data directly from the trial.

The Committee considered that the new modelling submitted by the company in its response to consultation, that used an alternative modelling approach fitting overall survival from Study 19, was not clearly explained and it was concerned about its validity. It was therefore not persuaded that the results of the alternative modelling approach provided the appropriate reassurance that the company's model produced a robust estimate of the overall survival gain of olaparib.

Incorporation of Health-related Quality-of-Life Benefits and Utility Values. Have Any Potential Significant and Substantial Health-related Benefits

Been Identified That Were Not Included in the Economic Model, and How Have They Been Considered?

The Committee concluded that some of the utility estimates lacked face validity, but accepted that utility values were not key drivers of the cost-effectiveness results.

The Committee could not identify any substantial health benefits that had not been captured in the quality-adjusted life year (QALY) estimates.

Are There Specific Groups of People for Whom the Technology Is Particularly Cost Effective?

None were identified.

What Are the Key Drivers of Cost-effectiveness?

A key driver of the cost-effectiveness results was the estimate of overall survival used in the model (that is, whether it was derived from the model or based on trial data) and the parametric survival curves applied to the distribution of time from first subsequent treatment or death.

Most Likely Cost-effectiveness Estimate (Given as an ICER)

The company's further analysis, submitted in response to consultation, that incorporated the costs of tumour testing in line with the Committee's preference (and corrections to 2 minor errors in the model identified by the Evidence Review Group [ERG]) produced a probabilistic ICER of £51,600 for olaparib compared with routine surveillance. However, the Committee considered that this was likely to be an underestimate of the true ICER because it overestimated the overall survival gain associated with olaparib.

The Committee was aware that using an alternative modelling approach fitting overall survival from Study 19, and including the costs of somatic testing, produced ICERs ranging from £37,900 to £66,500 using independent fitting models and £54,600 to £57,300 using a treatment-adjusted model. However, it was unsure of the validity of these results.

For the subgroup of people who received 3 or more lines of platinum-based chemotherapy before randomisation, the Committee concluded that the most plausible ICERs using independent fitting models were £46,600 to £46,800 per QALY gained (based on the log normal and log-logistic survival plots).

Patient Access Schemes (PPRS)

The company has agreed a patient access scheme with the Department of Health. This involves the National Health Service (NHS) paying for a patient's treatment with olaparib up to a certain time, with the company providing olaparib free-of-charge beyond that point and for as long as each individual patient continues to have olaparib.

Method of Guideline Validation

External Peer Review

Description of Method of Guideline Validation

Consultee organisations from the following groups were invited to comment on the draft scope, Assessment Report and the Appraisal Consultation Document (ACD) and were provided with the opportunity to appeal against the Final Appraisal Determination (FAD).

- Manufacturer/sponsors
- Professional/specialist and patient/carer groups
- Commentator organisations (without the right of appeal)

In addition, individuals selected from clinical expert and patient advocate nominations from the professional/specialist and patient/carer groups were also invited to comment on the ACD.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of evidence supporting the recommendations is not specifically stated.

The Appraisal Committee considered clinical and cost-effectiveness evidence submitted by the manufacturer of olaparib and a review of this submission by the Evidence Review Group (ERG). The main clinical effectiveness evidence came from one randomised controlled trial. For cost-effectiveness, the Appraisal Committee considered an economic model submitted by the manufacturer.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

The Committee concluded that in Study 19, olaparib increased progression-free survival (PFS) and time to subsequent therapy compared with placebo, in the whole trial population and in the breast cancer susceptibility gene gene-mutated (BRCAm) subgroup. It also concluded that because of the immaturity of the data and subsequent use of a poly-ADP-ribose polymerase (PARP) inhibitor in some patients, there was uncertainty about whether, and to what extent, olaparib increases overall survival compared with placebo.

Potential Harms

The summary of product characteristics lists the following very common adverse reactions for olaparib: decreased appetite, headache, dizziness, dysgeusia, nausea, vomiting, diarrhoea, dyspepsia, and fatigue.

For full details of adverse reactions and contraindications, see the summary of product characteristics.

Contraindications

Contraindications

For full details of adverse reactions and contraindications, see the summary of product characteristics.

Qualifying Statements

Qualifying Statements

- The recommendations in this guidance represent the view of the National Institute for Health and Care Excellence (NICE), arrived at after careful consideration of the evidence available. When exercising their judgement, health professionals are expected to take this guidance fully into account, alongside the individual needs, preferences and values of their patients. The application of the recommendations in this guidance are at the discretion of health professionals and their individual patients and do not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.
- Commissioners and/or providers have a responsibility to provide the funding required to enable the guidance to be applied when individual health professionals and their patients wish to use it, in accordance with the National Health Service Constitution. They should do so in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities.

Implementation of the Guideline

Description of Implementation Strategy

- Section 7(6) of the National Institute for Health and Care Excellence (NICE) (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013 requires clinical commissioning groups, National Health Services (NHS) England and, with respect to their public health functions, local authorities to comply with the recommendations in this appraisal within 3 months of its date of publication.
- The Welsh Assembly Minister for Health and Social Services has issued directions to the NHS in Wales on implementing NICE technology appraisal guidance. When a NICE technology appraisal recommends the use of a drug or treatment, or other technology, the NHS in Wales must usually provide funding and resources for it within 3 months of the guidance being published.
- When NICE recommends a treatment 'as an option', the NHS must make sure it is available within the period set out in the paragraphs above. This means that if a patient has relapsed, platinum-sensitive ovarian, fallopian tube or peritoneal cancer with breast cancer susceptibility gene (BRCA1 or BRCA2) mutations that has responded to platinum-based chemotherapy, and the doctor responsible for their care thinks that olaparib is the right treatment, it should be available for use, in line with NICE's recommendations.
- The Department of Health and AstraZeneca have agreed that olaparib will be available to the NHS with a patient access scheme. The drug cost of olaparib for people who remain on treatment after 15 months will be met by the company. It is the responsibility of the company to communicate details of the discount to the relevant NHS organisations. Any enquiries from NHS organisations about the patient access scheme should be directed to Matthew.Dyer@astrazeneca.com or Jane.Robertson@astrazeneca.com.

Implementation Tools

Foreign Language Translations

Mobile Device Resources

Patient Resources

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

End of Life Care

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

National Institute for Health and Care Excellence (NICE). Olaparib for maintenance treatment of relapsed, platinum-sensitive, BRCA mutation-positive ovarian, fallopian tube and peritoneal cancer after response to second-line or subsequent platinum based chemotherapy. London (UK): National Institute for Health and Care Excellence (NICE); 2016 Jan 27. 44 p. (Technology appraisal guidance; no. 381).

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2016 Jan 27

Guideline Developer(s)

National Institute for Health and Care Excellence (NICE) - National Government Agency [Non-U.S.]

Source(s) of Funding

National Institute for Health and Care Excellence (NICE)

Guideline Committee

Appraisal Committee

Composition of Group That Authored the Guideline

Not stated

Financial Disclosures/Conflicts of Interest

Committee members are asked to declare any interests in the technology to be appraised. If it is considered there is a conflict of interest, the member is excluded from participating further in that appraisal.

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Available from the National Institute for Health and Care Excellence (NICE) Web site. Also available for download in ePub and eBook formats from the NICE Web site.

Availability of Companion Documents

The following are available:

- Olaparib for maintenance treatment of relapsed, platinum-sensitive, BRCA mutation-positive ovarian, fallopian tube and peritoneal cancer after response to second-line or subsequent platinum-based chemotherapy. Costing report. London (UK): National Institute for Health and Care Excellence (NICE); 2016 Jan. 9 p. (Technology appraisal guidance; no. 381). Available from the National Institute for Health and Care Excellence (NICE) Web site.
- Olaparib for maintenance treatment of relapsed, platinum-sensitive, BRCA mutation-positive ovarian, fallopian tube and peritoneal cancer after response to second-line or subsequent platinum-based chemotherapy. Costing template. London (UK): National Institute for Health

and Care Excellence (NICE); 2016 Jan. (Technology appraisal guidance; no. 381). Available from the NICE Web site .

- Tappenden P, Harnan S, Ren K, Thokala P, Wong R, Mukuria C, Green C, Pledge S, Tidy J. Olaparib for maintenance treatment of BRCA 1 or 2 mutated, relapsed, platinum-sensitive ovarian, fallopian tube and peritoneal cancer in people whose relapsed disease has responded to platinum-based chemotherapy. Single technology appraisal. Sheffield (UK): School of Health and Related Research (ScHARR), The University of Sheffield; 2015 Mar. 240 p. Available from the NICE Web site .
- Olaparib as a monotherapy for the maintenance treatment of adult patients with platinum-sensitive relapsed (PSR) BRCA-mutated (germline and/or somatic) high-grade, serous epithelial ovarian, fallopian tube or primary peritoneal cancer who are in response (complete response or partial response) to platinum-based chemotherapy. Single technology appraisal (STA). Manufacturer's submission. AstraZeneca; 2015 Jan. 269 p. Available from the NICE Web site .

Patient Resources

The following is available:

- Olaparib for maintenance treatment of relapsed, platinum-sensitive, BRCA mutation-positive ovarian, fallopian tube and peritoneal cancer after response to second-line or subsequent platinum-based chemotherapy. Information for the public. London (UK): National Institute for Health and Care Excellence (NICE); 2016 Jan. 3 p. (Technology appraisal guidance; no. 381). Available from the National Institute for Health and Care Excellence (NICE) Web site . Also available for download in ePub and eBook formats from the NICE Web site . Also available in Welsh from the NICE Web site .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

This NGC summary was completed by ECRI Institute on April 14, 2016.

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